

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Jack

Registration District No. 390

Township Blue

Primary Registration District No. 1002

City Kansas City, Mo. (No. Leeds T. B. Hospital)

File No. 1177

Registered No. 245

St. Ward

2. FULL NAME

(a) Residence. No. 3639 Prospect

(Usual place of abode)

St. 14

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 11 mos. 10 ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb. 8 - 1906

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

25

11

10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

none

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Edw. Rodecker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Blanche Graven

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT
(Address)

T. B. Hospital
Leeds, Mo.

15.

FILED

1/19/32 m m Crow

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan. 18 1932

17.

I HEREBY CERTIFY, That I attended deceased from

Nov. 15, 1930 to Jan. 18, 1932

that I last saw him alive on Jan. 18, 1932 and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis T.A.
Tuberculosis of Intestine

CONTRIBUTORY (SECONDARY)

Myocarditis

(duration) yrs. 6 mos. ds.

(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

Kansas City Mo

DID AN OPERATION PRECEDE DEATH?

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

W. H. Smith M. D.

. 19

(Address)

Kansas City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Mt. Washington

1-20 1932

20. UNDERTAKER

ADDRESS

Mrs. E. L. Foster

K. C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

